Gaming the System

Dodging the Rules, Ruling the Dodgers

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•Although traditional obligations of fidelity require physicians to deliver quality care to their patients, including to utilize costly technologies, physicians are steadily losing their accustomed control over the necessary resources. The "economic agents" who own the medical and monetary resources of care now impose a wide array of rules and restrictions in order to contain their costs of operation. However, physicians can still control resources indirectly through "gaming the system," employing tactics such as "fudging" that exploit resource rules' ambiguity and flexibility to bypass the rules while ostensibly honoring them. Physicians may be especially inclined to game the system where resource rules seriously underserve patients' needs, where economic agents seem to be "gaming the patient," with needless obstacles to care, or where others, such as hospitals or even physicians themselves, may be denied needed reimbursements. Though tempting, gaming is morally and medically hazardous. It can harm patients and society, offend honesty, and violate basic principles of contractual and distributive justice. It is also, in fact, usually unnecessary in securing needed resources for patients. More fundamentally, we must reconsider what physicians owe their patients. They owe what is theirs to give: their competence, care and loyalty. In light of medicine's changing economics, two new duties emerge: economic advising, whereby physicians explicitly discuss the economic as well as medical aspects of each treatment option; and economic advocacy, whereby physicians intercede actively on their patients' behalf with the economic agents who control the resources.

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> Pauline Stafford had lung cancer. Before surgery, Mrs. Stafford was referred for computed tomography to determine whether the cancer had yet metastasized to her brain. Her insurance did not cover screening procedures, however, and would reject the claim if "rule out brain tumor" were written the space marked "diagnosis." And so the physician directed his office staff to write "brain tumor," even though the test showed she had no tumor. When Pauline subsequently received in the mail a statement of her insurance benefits she saw the entry under "diagnosis" and concluded the worst. Two days later, after preparing her husband's dinner and typing out his daily business agenda, Stafford hanged herself. On the appeal of a $200,000 verdict against the physician and Neurological medicine, Inc, the US Court of Appeals upheld the jury's finding that the erroneous entry on the claim form was the proximate cause of Stafford's suicide and ruled that their financial award to her husband was not excessive.[1]

The case of Pauline Stafford is not only a sad story. It captures one of the most vexing dilemmas of medicine's changing economics: physicians are expected to deliver quality care to their patients, including sometimes to utilize costly technologies, yet they are steadily losing their accustomed control over the necessary medical and monetary resources. No longer will insurers cheerfully pay out large sums, simply on a physician's say-so. However, physicians can still exert considerable indirect influence over resources by "gaming the system," using tactics such as "fudging" that enable one to skirt resource rules while appearing to comply with them. In this paper we will see

how this awkward situation has come about, why "gaming" can be tempting, why it is hazardous, and most importantly, how this predicament forces us fundamentally to reevaluate physicians' obligations to their patients.

PHYSICIANS' OBLIGATIONS, OTHERS' RESOURCES

We can be brief in exploring the origins of the problem, for that groundwork has been laid elsewhere.[2-4] It begins with physicians' obligations of fidelity to their patients. Traditionally, fidelity is necessary because patients are vulnerable. They may have physical, emotional and intellectual infirmities; their usually minimal medical knowledge requires them to trust in the physician's expertise; and treatment often requires them to expose personal intimacies and sometimes to incur substantial risk. Physicians therefore are obligated to be medically competent and to promote the patient's interests, even above their own.[5]

Over the years, medical competence has come to include not only the duty to keep abreast of new information, but to use appropriate technologies, such as x-rays and biopsies.

If physicians, as an aid to diagnosis, ie, judgment, do not avail themselves of the available scientific means and facilities for the collection of the *best* factual data upon which to arrive at the diagnosis, the rest is not an error of judgment but negligence in failing to secure an adequate factual basis on which to support that diagnosis or judgment.[6 (p. 173), 7-9]

Furthermore, in requiring the physician simply to "take the x-rays, or have them taken,"[10] and to keep patients in the hospital as long as is medically necessary (regardless of insurers' reimbursement decisions,"[11] courts have shown little or no interest in who owns the x-ray equipment or hospital bed, or who must pay the staff who tend them. "Whether the patient be a pauper or a millionaire, whether he be treated gratuitously or for reward, the physician owes him precisely the same measure of duty, and the same degree of skill and care.[12 (p. 677)] White it is unclear just how far physicans' legal duties to use technologies actually reach (eg, the physican is not required to purchase the patient's prescription medications out of his or her own pocket), the physician is usually well-advised to use whatever technological resources are clearly part of the standard of care.[4]

Morally, it has similarly been routine to believe that physicians in the clinical setting "are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations."[13 (p. 1573)] The physician's duty is to the patient, not to society or to insurers.[14-16]

In essence, then, physicians have been expected virtually to commandeer other people's money and property for the benefit of their patients. For many years such economic indifference was plausible. Insurance, both private and government, was structured to insulate patient and provider from worrying about costs.[16] Reimbursement was retrospective and usually generous, and cost-shifting (providers' practice of raising charges to paying patients in order to cover nonpaying patients) covered many of the uninsured who found their way into the health care system.

In reaction to three decades' explosive expansion in health care expenditures, however, the "economic agents" who furnish the medical and monetary resources of care are no longer willing to stand as silent partners funding whatever physician and patient choose to do. Government, business, insurers, institutional providers such as hospitals and health maintenance organizations, and virtually everyone else with a major financial stake in health care now control their resources with a striking array of cost-containment and profit-producing measures, ranging from managed care and intensive utilization review to caps on coverage and restrictions on eligibility. The physician thus finds himself or herself increasingly trapped between traditional mandates to deliver unstinting resources to patients and a progressive loss of the power to do so.[4,17] And if physicians try to avoid this predicament by becoming themselves owners of the relevant resources, they can create formidable conflicts of interest between themselves and their patients.[6]

GAMING: DEFINITION, DEVICES

While physicians have lost much of their direct control over resources, in fact they retain considerable indirect control. Where economic agents' resources rules seem to impede care, the physician can usually find ways to game the system, to bypass those rules while still appearing to honor them and thereby to secure resources that were not, technically at least, intended for this patient.

This room for manipulation has two sources. First, all resource rules leave room for interpretation. They must be articulated with language, and language is inherently vague, as it uses a limited number of verbal concepts to

capture the infinite variety of experience. Reimbursement based on diagnosis-related groups, for example, requires the physician to state the patient's diagnosis. Yet, in fact, it is often possible for the physician to describe his patient's condition in a variety of ways. The physician might describe the patient's episode as a "probable transient ischemic attach" or as a "possible stroke," depending on which will yield better reimbursement.[18-19]

Second, resource rules must leave flexibility for individuality of care. Medically, patients and their illnesses are too complex and diverse to be described adequately by any "cook-book" or computer.[2-3] And legally, insurers and hospital administrators who dared to dictate the daily details of care might be accused of practicing medicine without a license[20] or, at least, could increase their own exposure to tort liability." Therefore, they often are willing to accede to the physician who insists that a patient needs some particular intervention,[21] or at least to negotiate some mutually acceptable course of care.[22]

Between the resource rules' unavoidable vagueness and their necessary flexibility then, the creative physician can invent numerous ways to game the system. Not all manipulation of resources rules counts as gaming, of course. When resource rules are substantially ambiguous, the physician might simply select whichever fully correct description of the patient's condition will produce the most favorable application of the resource rules. For a Medicare patient with multiple medical problems, for instance, one can list renal failure rather than diabetes or hypertension as the "principal diagnosis," thereby maximizing the hospital's diagnosis-related group reimbursement.

Gaming does not begin until the physician pushes harder against a proper fit between language and reality. He may fudge, using florid descriptions to exaggerate the seriousness of the patient's condition to a utilization review officer who has been reluctant to authorize hospitalization,[21] or he or she might install an intravenous line in a patient who has no need for intravenous medication, solely to ensure such a utilization review authorization. There are many methods and degrees of fudging, short of outright lying, and many physicians have expressed willingness to resort to such tactics on occasion.[23]

At the extreme, the stretch and push of fudging merges into the flagrant dishonesty of fraud. The plastic surgeon may say that this patient's rhinoplasty was "necessitated" by a (fictitious) ski accident. The internist may file claims for tests that were never performed or for patients who do not exist, or may secure payment several times for a single procedure (*Wall Street Journal* December 6, 1989; A-1, A-8).

Gaming is not only easily available. It is now sorely tempting, because it seems to offer escape from an impossible situation by allowing physicians to secure indirectly what they no longer control directly. The physician still manages to extract the hospital admission or the costlier therapy, despite third parties' refusals or reluctance.

THE CASE FOR GAMING

Gaming is particularly tempting in two kinds of situations. First, many patients lack adequate health care coverage. Almost 40 million Americans have no medical insurance. Where formerly many of these people had at least some gratuitous entry into the health care system,

the disappearance of cost shifting has left many of these people wither in overcrowded hospitals or without care altogether. Beyond this, many insurance policies are not comprehensive. An infant recovering from meningitis may be medially ready to leave the hospital receiving oral antibiotics without, for example, but if his or her 14-year-old, illiterate mother is unlikely to adhere to the necessary outpatient regiment, the physician may want to "find" some further "medical problem" that "requires" a longer inpatient stay. The medical orientation of most insurance rules leaves little room for such medically significant social problems of for the psychosocial component of many medical problem.[24] Similarly, many physicians are disturbed by insurers' traditional refusal to cover screening tests and other important preventive care. Even insurance coverage that is basically adequate can precipitate problems. Many patients, unaccustomed to paying for medical care and now facing higher cost sharing or reduced coverage, may pressure their physicians to waive their copayments of to "get the insurance to pay" for services not covered by their policies or health maintenance organizations plans.

Second, patients do not always receive even the resources to which they are entitled. Some insurers have developed a truly awe-inspiring array of tactics by which to avoid or delay making the payments they owe.[25] In other cases an unsophisticated utilization review clerk may deny approval to reimburse hospitalization for a condition that clearly requires it, as where a patient has a clinically obvious even if atypical presentation of appendicitis. Or in some instances the physician may question the patient's health care policy at a fundamental level. A health maintenance organization may lure subscribers with promises

that "we provide all the care you'll ever need," yet fail to disclose an assortment of coverage limits, incentive systems, and barriers to care.[26-29] Where there is good reason to suspect that the payer is "gaming the patient," the physician may be sorely tempted to dodge its rules.

Note, patients are not the only ones whose needs may be ill-served by resource rules. Hospitals, too, can suffer where payers refuse to pay, or where they must care for too many indigent patients. Likewise, physicians' fees are increasingly the targets of cost containment. We can argue that physicians need to take their own incomes seriously as a moral issue,[30] and that greed can never justify gaming. We may also agree that physicians and hospitals ought to provide at least some uncompensated care for indigent patients, yet we must acknowledge that these obligations are not unlimited. It is unfair to expect providers alone to make up for the broader society's lack of a comprehensive health care system.

THE CASE AGAINST GAMING

Though gaming can be powerfully attractive in a system that leaves many patients with inadequate health care resources, and that still expects physicians generously to deliver resources that they no longer fully control, it also carries formidable moral and medical hazards. It can violate principles of nonmaleficence, veracity and justice.

Nonmaleficence is the principle of avoiding harm. Gaming can harm the very patient it is intended to help, as sadly evidenced by the case of Pauline Stafford. Even if we argue that the immediate harm to Stafford could have been avoided if the physican had explained his 'creative

accounting' system ahead of time, an important indirect harm could thereby be done to her trust for him. If he is so cheerfully willing to lie for her, perhaps he is equally willing to lie to her. Moreover, such an explanation can place the patient in a very awkward position. One who does not morally approve of such deception must either challenge the physician's integrity outright, or must be an uneasy silent accomplice to the dishonesty. Further, if a physican exaggerates the seriousness of a patient's condition to utilization review officers on the telephone, he or she may have to write those exaggerations in the chart, thus jeopardizing the patient's future care. Similarly, a phychiatrist who identifies a patient's illness according to the most serious, best-reimbursed diagnosis, he may needlessly stigmatize the patient elsewhere in life.

Other patients, too, can be directly harmed. If a physician gains entry for a patient into a crowded coronary intensive care unit by (mis)describing the patient's exertional angina as "unstable," some needier patient may be denied admission. Physicians can even hurt themselves. If an adverse medical outcome happens later to lead to litigation, even altruistically motivated fudging could undermine the physician's credibility in the eyes of a jury.

Everyone can be harmed by gaming. Where physicians routinely game their way around an undesirable resource rule instead of openly challenging it, they may help to perpetuate unwise policies. Thus, if insurers' refusal to cover reasonable screening tests is as medically and economically counterproductive as many physicians believe, surely it is better to challenge this policy than to preserve it by pretending to honor it.

Gaming also offends veracity. Virtually every act of gaming features some duplicity, for by definition gaming is an attempt to bypass resource rules while still appearing to honor them. We need not belabor the importance of honesty. It is a basic tenet of moral integrity, of respect for other persons, and of successful communication and cooperation in a community.[31] Furthermore, no resource system can long survive widespread abuse and dishonesty, nor can physicians expect to retain either their professional integrity or, equally important, their clinical autonomy, if they treat with duplicity those who own the medical and monetary resources essential to their patients' care.[22] While the wrong is blatant where the physician games for personal gain, it is also formidable when done to help the patient.[32] It is therefore, difficult to defend even the marginal duplicity of fudging, and probably impossible ever to justify outright fraud.

Finally, gaming can offend both contractual justice and distributive justice. Contractual justice concerns fair exchange, honest dealing, and keeping one's promises.[2] Here we especially note the contract between patient and payer. The patient, perhaps through his or her employer, has paid a specified amount for a designated, and limited, list of services. Admittedly, the physician plays an important role in this contract. He or she recommends medical services to the patient and often controls the patient's access to them through his power of prescription. The physician even controls the patient's access to third-party reimbursements, as insurers require the physician signature attesting to what was done, and why.

However, this does not entitle the physician to override, undermine or otherwise "correct" the contract between patient and insurer solely because he personally

has judged it to be inadequate. So long as our health care system is based on free enterprise and voluntary negotiation among competent individuals and groups, widespread gaming represents not only an assault on legitimate agreements, but an invitation to economic anarchy. Contractual justice is better served when bad contracts are openly challenged than when they are covertly undermined.

In government insurance, too, recipients' entitlements are created, also with express limits, through a kind of contract among citizens and their legislators. Where policies are unwise or inadequate they should be corrected not by a gaming that undermines both the social decision and the democratic process by which it was made but, rather, through public discussion.

Gaming can also offend distributive justice, the basic fairness with which scarce resources are allocated.[2] Scarcity means that not everyone can have everything that he or she needs. Therefore, even the fairest possible system for distributing health care resources will have unfortunate consequences in individual cases. Gaming is tempting in such cases because, if successful, it can help those individuals to avoid those consequences. Yet, if the overall distribution system is just, these individuals who extract more than their share, even for the worthwhile goal of better health, are unjustly freeloading at others' expense. If scarce resources are to be distributed fairly, all must cooperate.

Even in societies like the United States where the health care distribution system is far from just, distributive justice would still ask the physicians to refrain from gaming to gain extra resources for their own patients.

Gaming, if widespread enough, can destroy any system of resource rules. Unless the distribution system is so seriously unjust it warrants classic civil disobedience or even revolutionary overthrow, it is usually better to preserve order through that system even while one remedies its faults through open political processes.[2,3]

In sum, then, although there are powerful reasons to game resource rules where one's patient seems to be denied a needed or even entitled resource, moral principles of nonmaleficence, veracity and justice would oppose gaming. Fortunately, a better answer is available from two sources: a practical look at the actual mechanics of health care financing, and a moral reexamination of physicians' traditional fidelity obligations to their patients.

ECONOMIC PRACTICALITIES

Practically, a physician's inclination to game is often based on empirical assumptions that commonly are, in fact, incorrect. The physician may assume, for example, that a current denial of funding constitutes a permanent denial. However, in most cases this is not actually true. All utilization review systems have mechanisms for appealing lower-level decisions and, more importantly, it is rare for prospective review to result in a flat denial of funding for care that a physician seriously argues is necessary. Usually, either the physician's original plan is accepted after further discussion or else some mutually agreeable compromise is negotiated.[22]

Similarly, where funding actually is denied or unavailable, a physician may assume that further care for the patient is thereby precluded. This assumption, too, is

often erroneous, for it may be possible to find or invent alternative options. If an elderly widow is medically ready for discharge from the hospital but lacks adequate support services at home, the better remedy is to arrange for those home services, not to hold her indefinitely in a costly inpatient facility. A bit of inventiveness in recruiting family and friends can often solve the problem even in the absence of designated funds or formal programs for home care.

Even absent such alternatives, a denial of money does not entail a denial of care. When Medicare's hospital payment has been exhausted, the patient is not automatically discharged. The denial of further funding means only that continued hospitalization must be funded from somewhere else, whether by seeking money from a charitable organization, by adding to the hospital's burden of uncompensated debt, or even by expecting the patient to pay where he or she is obligated and able to do so. Similarly, a Medicaid refusal to cover well-baby care is not a denial of care to the baby, but of payment to the physician.

In these ways, the gaming that the physician may feel so urgently necessary is, as a matter of fact, quite avoidable. Gaming is often selected not because there is no other way to secure a needed resource, but because it is more obvious or convenient than searching for alternatives. Of course, there usually are alternatives: one can appeal, invent, negotiate, find money elsewhere, or provide services at no cost.

But here we encounter a major moral challenge. To demand this level of effort seems still to presume, as in our traditional view of fidelity, that the physicians are personally responsible to deliver resources to patients,

regardless of the costs to themselves or others. In the new economics of medicine, this requirement now seems untenable. We need to reexamine traditional obligations of fidelity as they concern resources.

FIDELITY RECONSIDERED

Our expectation that physicians should generously deliver other people's money and property to their patients is largely a product of history. Until relatively recently, physicians mostly had only their own care and concern to offer. As medical technologies emerged, generous third-party coverage, plus cost-shifting, generally made it possible for physicians, patients, courts and moral observers all to ignore costs. And yet, in the cold light of current resource constraints, it makes little sense to maintain this moral and economic anachronism.

The economic agents who provide health care's resources are not "intruders"[88] into the physician-patient relationship. In many ways, they make that relationship possible. The wisest, most skilled physician can do little without tools. And where the necessary tools are costly and scarce, and are owned or paid for by third parties, then physician and patient alike have an obligation to respect these agents' legitimate interests and resource restrictions.

If physicians are not obligated to deliver to their patients are that which they neither own nor control, then what do they owe? They owe what is their to give: their professional competence and loyalty as always and, in the new era of resource restrictions, their best efforts at advising and advocacy. Physicians have always owed their

patients medical advising and medical advocacy, of course, but now we must add an economic dimension, on both a clinical level and a profession-wide level.

On the clinical level, physicians need to advise their patients more closely concerning the economic changes in health care. In an important sense, patients are the "ultimate payers" for health care. As employees, they forgo salary or fringe benefits or cover the rising cost of health insurance; as consumers, they pay higher prices for products as businesses try to recoup the increasing cost of employees' health benefits; as taxpayers they see rising taxes or reduced government services as a deficit-ridden government seeks to trim what expenditures it can; as patients, they must directly pay higher copayments and deductibles and bear the medical consequences of cost-care tradeoffs. It is therefore fitting that patients play a much greater role in choosing whatever tradeoffs must be made.

To make these judgments, patients must know the price tags on their medical options. And this requires that physicians themselves become far more aware of the actual costs of care. They must be open about their own fees, and must try to learn the costs of the medications, tests, and other care they prescribe.[34] While this task may seem onerous, it is now necessary, for patients are entitled to know and to help decide the ways in which medicine's changing economics (including the conflicts of interest that this can create between patient and physician[5,35,36]) will affect their care. Where patients know more about their costs from the outset, they may even be less likely to pressure physicians inappropriately to "get the insurance to pay" for that screening test or cosmetic surgery that is expressly excluded by their policy.

Advocacy, like advising, is not a new concept in medicine. But when applied to economics, it carries some new responsibilities. Contrary to common views, advocacy does not require the physician simply to deliver resources to the patient. Rather, an advocate is "one who pleads, intercedes, or speaks for, or in behalf of, another."[37] While the physicians do not necessarily control or own the resources they seek for their patients, they can vigorously intercede on their patient's behalf.

Economic advocacy is no longer a personal favor that the physician may or may not choose to do for the patient. It is an important part of the physician's job, because otherwise the patient will have little or no access to essential monetary as well as medical resources. Thus, while we can no longer say that physicians owe their patients other people's resources, they do owe their own efforts to secure resources. The duty is now gaining recognition in commonlaw. In one case, Herbert Chew, a steel company worker who had undergone surgery, asked his surgeon, Dr Meyer, to document for his employer that Chew's absence from work was medically necessary. Meyer reluctantly agreed to have his secretary complete the necessary forms but, despite several inquiries and proddings from Chew, did not in fact send the forms until after Chew had had been fired from his job for failure to furnish that very documentation. The Maryland Court of Special Appeals noted that the physician's promise constituted an undertaking that, although perhaps gratuitously made, carried a duty to discharge the promise in a proper and timely manner.

The court also found another important basis for liability. In earlier times, the court argued, the plaintiff's claim might well have been summarily rejected, on the

basis that a physician's obligation ordinarily did not extend beyond their duty to use their best efforts to treat and cure. The traditional scope of the contractual relationship between physician and patient, however, has expanded over the years as a result of the proliferations of health and disability insurance, sick pay, and other employment benefits. Today, the patient commonly, and necessarily, enlists the aid of his or her physician in preparing claims for health and disability. Such forms ordinarily require information possessed solely by the treating physician as well as the physician's signature attesting to the bona fides of that medical information.[38 (p. 832)] The physician therefore, the court concluded, has a duty to assist the patient in such economic matters. As a profession, physicians have further duties of economic advising and advocacy, namely, to help policymakers to write medically credible resource rules and to help change those that are not. Fortunately, such advisory efforts are already underway.[2,39,40]

CONCLUSION

In the end, then, I cannot recommend gaming as a strategy for coping with the admittedly frightening changes in medicine's economics. It is short-sighted, medically and morally hazardous, and usually unnecessary. Our real moral challenge now is to explore more closely the duties – and the limits – of economic advising and advocacy. Just as physicians should not be expected to commandeer others' money and property, so is it unreasonable to expect literally limitless efforts in appealing odd resource rulings, locating new sources of funding, or providing free care. Our agenda for the future, then, must

be not only to explore more closely the new fidelity of medical ethics, but also to consider how to forge a more rational health care structure, one that will not call for physicians so constantly to battle resource rules in order to secure care for their patients.

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